South Carolina Department of Health and Human Services

FY21-22 Proviso 117.119 (C) – Telehealth Report

This report is issued pursuant to Section 117.119 (C) of Act 94 of 2021.
"The Department of Health and Human Services shall continue to identify and implement telehealth benefits and policies that are evidence-based, cost efficient, and aligned with the needs of the Medicaid population. The department must also continue to review the temporary telephonic and telehealth flexibilities it has adopted to address the COVID-19 public health emergency and make permanent those that are suitable for inclusion in the Medicaid benefit. No later than October 1, the department shall submit a report to the Governor, the Chairman of the Senate Finance Committee, and the Chairman of the House Ways and Means Committee on policy and benefit changes it has introduced in the furtherance of this goal and as part of its ongoing effort to improve the sustainability of telehealth services."

I. Introduction

The South Carolina Department of Health and Human Services (SCDHHS) has operated a telehealth program since 2011. Telehealth provides an additional option for delivering certain covered services, when appropriate, rather than a separate set of benefits. During the current coronavirus disease 2019 (COVID-19) public federal public health emergency (PHE), the department has modified its existing telehealth program to provide needed flexibilities in the delivery of care as the pandemic continues to bring drastic change to healthcare delivery systems across the world. This report will provide a review of the department's pre-pandemic telehealth program, discuss the flexibilities that were put in place to ensure access to care during the pandemic, evaluate utilization data and provide an outlook for the future direction of SCDHHS' telehealth program.

In determining the appropriate role of telehealth in the Medicaid benefit, SCDHHS balances the tenets of cost, quality, and access.

- *Cost*: From a cost perspective, ideal targets for telehealth provide opportunities to triage patients away from more costly places of service or provide follow-up care that does not need to involve face-to-face interaction.
- *Quality*: While evidence supporting the use of telehealth continues to mount, care must be taken to ensure services provided via telehealth are delivered with the same quality as if engaging the member in a face-to-face interaction.
- *Access*: Telehealth offers a unique opportunity to erase the geographic divides that separate many areas of our state, improving access to the statewide network of resources for the state's most underserved citizens. As these opportunities to enhance access become available, they must continue to be balanced with the needs to maintain quality of care and efficient use of taxpayer dollars.

II. Current and Pre-pandemic Coverage

Current SCDHHS coverage policy, established prior to the COVID-19 PHE, requires any healthcare professional providing medical services via telehealth to be:

- Currently and appropriately licensed in South Carolina;
- Meet Medicaid credentialing requirements;
- Be enrolled with the South Carolina Medicaid program; and,
- Be located within the South Carolina Medical Service Area (SCMSA), which is defined as the state of South Carolina and areas in North Carolina and Georgia within 25 miles of the South Carolina state border.

SCDHHS provided coverage for the delivery of telehealth services from a consultant site to a referring site within the limitations described below.

- The consultant site (distant site) is the physical location where a specialty physician or practitioner providing medical care is located at the time the service is provided via telehealth.
- The referring site (patient site) is the location of a Medicaid member at the time the service is being furnished.

Referring site requirements have temporarily changed during the COVID-19 PHE and the department is considering making permanent changes to these requirements as described later in this report. Under the pre-pandemic definition, the referring provider is the provider who has evaluated the member, determined the

need for a consultation, and has arranged the services of the consulting provider for the purpose of consultation, diagnosis and/or treatment. Currently, physicians, nurse practitioners, and physician assistants may provide telehealth services from the consulting site. Prior to the COVID-19 PHE, Medicaid members receiving telehealth services were required to be physically located at a referring site that is also within the SCMSA. Referring site providers were also required to be proficient in the use of the telehealth-enabling technology and be present during the encounter to provide any clinical support necessary during the encounter. Referring sites covered by SCDHHS prior to the COVID-19 PHE included:

- Physician, nurse practitioner (NP), or physician assistant (PA) offices
- Hospitals (inpatient and outpatient)
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)
- Community Mental Health Centers
- Public schools
- Act 301 Behavioral Health Centers

Some services eligible for reimbursement prior to the COVID-19 PHE included consultation, office visits, psychotherapy, pharmacologic management, psychiatric diagnostic interview examinations and testing, electrocardiogram (EKG) interpretation, and echocardiography (ECG). Additional services eligible for reimbursement when provided via telehealth during the COVID-19 PHE are described later in this report.

Prior to the COVID-19 PHE, an audio and video telecommunication system that is Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant and that permits interactive communication between the physician or practitioner at the consultant site and the member at the referring site must be used as a condition of reimbursement. During the COVID-19 PHE, some services are eligible for reimbursement when provided via audio-only communication, also referred to as “telephonic services,” as described in this report. Visits that are conducted via telehealth are subject to benefit limitations and other requirements that apply when services are delivered through traditional models.

Additional requirements related to telehealth services can be found in the SCDHHS Physician Services Provider Manual.

III. COVID-19 Telehealth Flexibilities

In March 2020, a national emergency was declared due to COVID-19 and Governor Henry McMaster subsequently declared a state of emergency for the state of South Carolina. As a part of the state’s preparation and response to COVID-19, SCDHHS released a series of bulletins outlining policy modifications related to telehealth services to protect South Carolina Healthy Connections Medicaid members by ensuring ongoing access to care. These temporary policy changes have afforded providers the flexibility to ensure members continued to have access to care while supporting important social distancing measures.

The information included below outlines the administrative flexibilities related to telehealth as detailed in each Medicaid bulletin resulting from the declared federal PHE, which is currently set to expire on Dec. 31, 2021.

Medicaid Bulletin Release Date	Description of flexibility
March 19, 2020 Bulletin 20-004	• Allows services to be provided telephonically by a physician, NP, or PA to an established patient • Allows services to be provided telephonically by Licensed Independent Practitioners ([LIPs] licensed psychologists, licensed professional counselors [LPCs], licensed marriage and family therapists [LMFTs], licensed independent social worker-clinical practice providers [LISW-CPs] and licensed psycho- educational specialists [LPES]) to an established patient • Allows for remote images submitted by patient • Allows brief check in by provider
March 23, 2020 Bulletin 20-005	• Waives referring site restrictions (patient home allowed as referring site) • Waives requirement for certified/licensed professional to be present at referring site
March 25, 2020 Bulletin 20-007	• Allows FQHCs and RHCs to provide telehealth services and receive reimbursement above and beyond the approved encounter rate
March 27, 2020 Bulletin 20-008	• Allows services to be provided telephonically by physical therapists (PTs), occupational therapists (OTs), and speech therapists (STs) with established patients • Additional therapeutic and treatment services available via telehealth (e.g., therapeutic activities, therapeutic exercises, and treatment of speech, language, voice, communication, and/or auditory processing disorder)
March 28, 2020 Bulletin 20-009	• Additional behavioral health services available via telehealth for physicians, NPs, PAs and LIP providers (e.g., individual and family psychotherapy)
March 30, 2020 Bulletin 20-010	• Allows early intervention services to be provided telephonically and via telehealth
March 30, 2020 Bulletin 20-011	• Allows Applied Behavior Analysis services for treatment related to autism spectrum disorder via telehealth
April 3, 2020 Bulletin 20-013	• Allows for dental triage and evaluation services via telehealth (flexibility expired June, 2021)
April 6, 2020 Bulletin 20-014	• Allows telehealth services to be provided by associate-level providers (e.g., LPC associates, LMFW associates, Psychologist-Postdoctoral pending licensure)
April 16, 2020 Bulletin 20-015	• Allows well-child visits and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visits via telehealth • Allows FQHCs and RHCs to provide well-child visits and EPSDT visits via telehealth and receive reimbursement above and beyond the approved encounter rate
April 16, 2020 Bulletin 20-016	• Allows telehealth services to be provided to new patients, effectively updating bulletin 20-004 which allowed telehealth services for established patients only • Allows telehealth services to be provided by PT, OT, ST assistants • Allows telehealth services to be provided by licensed masters social workers (LMSWs)
May 1, 2020 Bulletin 20-017	• Allows management of medication-assisted treatment (MAT) services via telehealth

IV. Current Utilization

Telehealth utilization within the Medicaid program has increased significantly since its introduction. During the COVID-19 PHE, which included the last two quarters of SFY 2020 and the entirety of SFY 2021, telehealth utilization grew exponentially, totaling more than 626,000 encounters in SFY 2021. This growth represents a 1,362% increase from the onset of the COVID-19 PHE telehealth flexibilities introduced in March 2020. Year-over-year growth prior to the current COVID-19 PHE averaged 35%, as demonstrated in Figure 1 below.

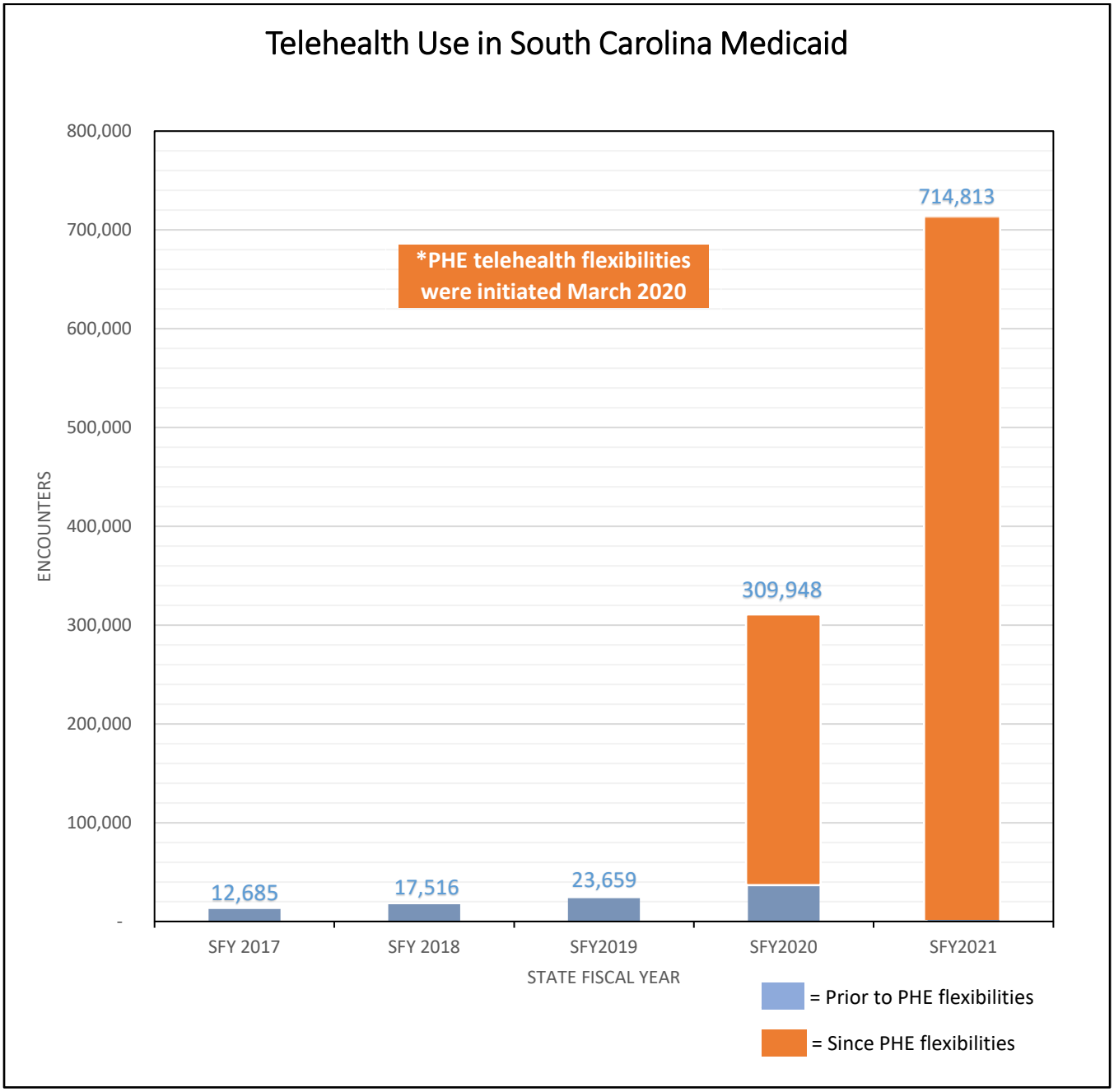

Figure 1 *Telehealth utilization, SFY 2017- SFY 2021 (claims)*

Since the onset of the COVID-19 PHE declaration in March 2020, telephonic services (audio-only) have also played a role in increasing access to care for South Carolina's Medicaid members. The graph below illustrates a quarterly comparison of utilization for audio-only services and traditional telehealth services (those that include a video component) since the introduction of COVID-19 PHE telehealth flexibilities. Encounters below represent claims received to date. Providers may submit claims up to 12 months after the date of service.

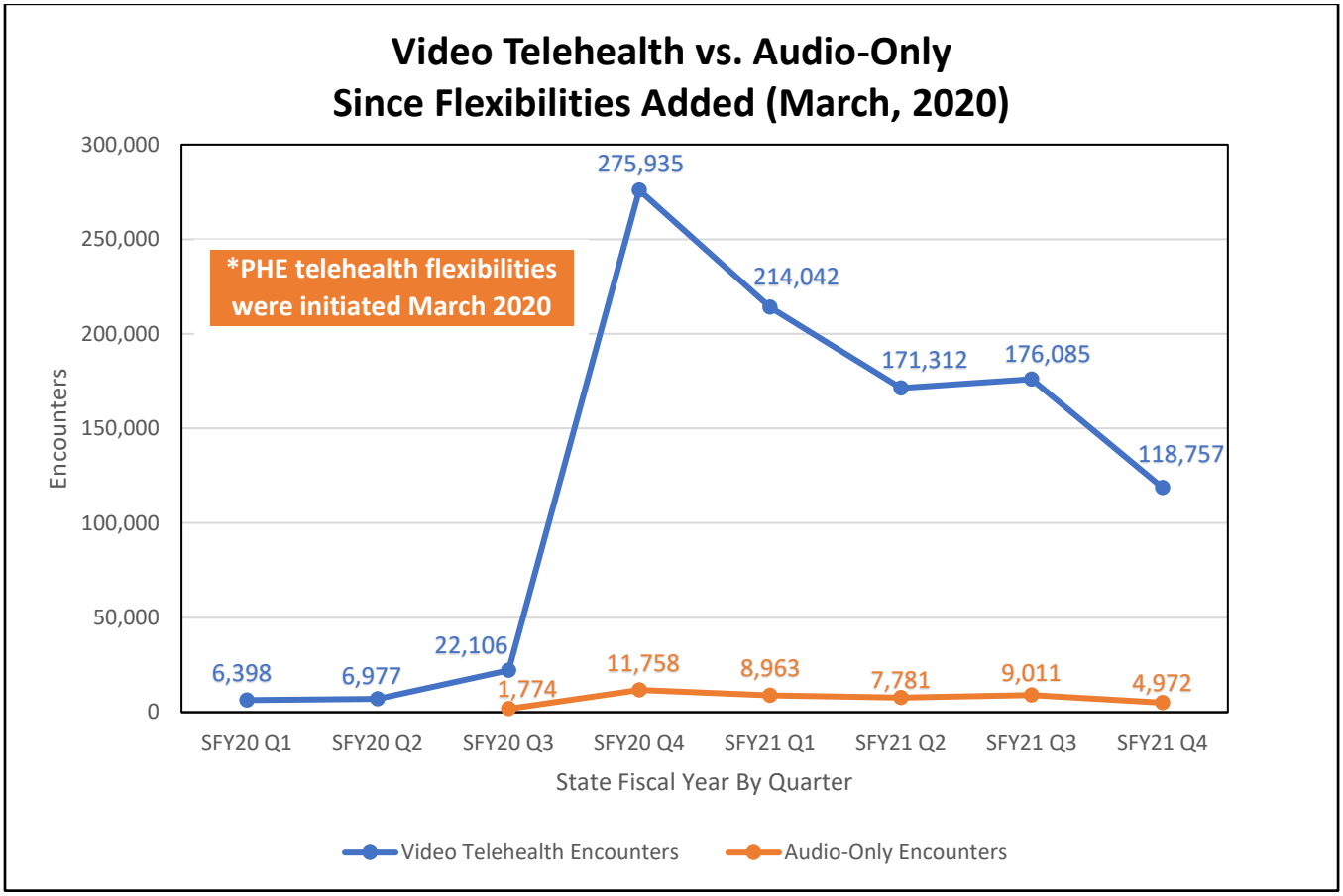

Figure 2 *Comparison of video telehealth and audio-only telehealth, SFY20 Q1 – SFY21 Q4*

Figure 3 and Figure 4 summarize utilization percentage by provider type and service type respectively since the introduction of the COVID-19 PHE telehealth flexibilities.

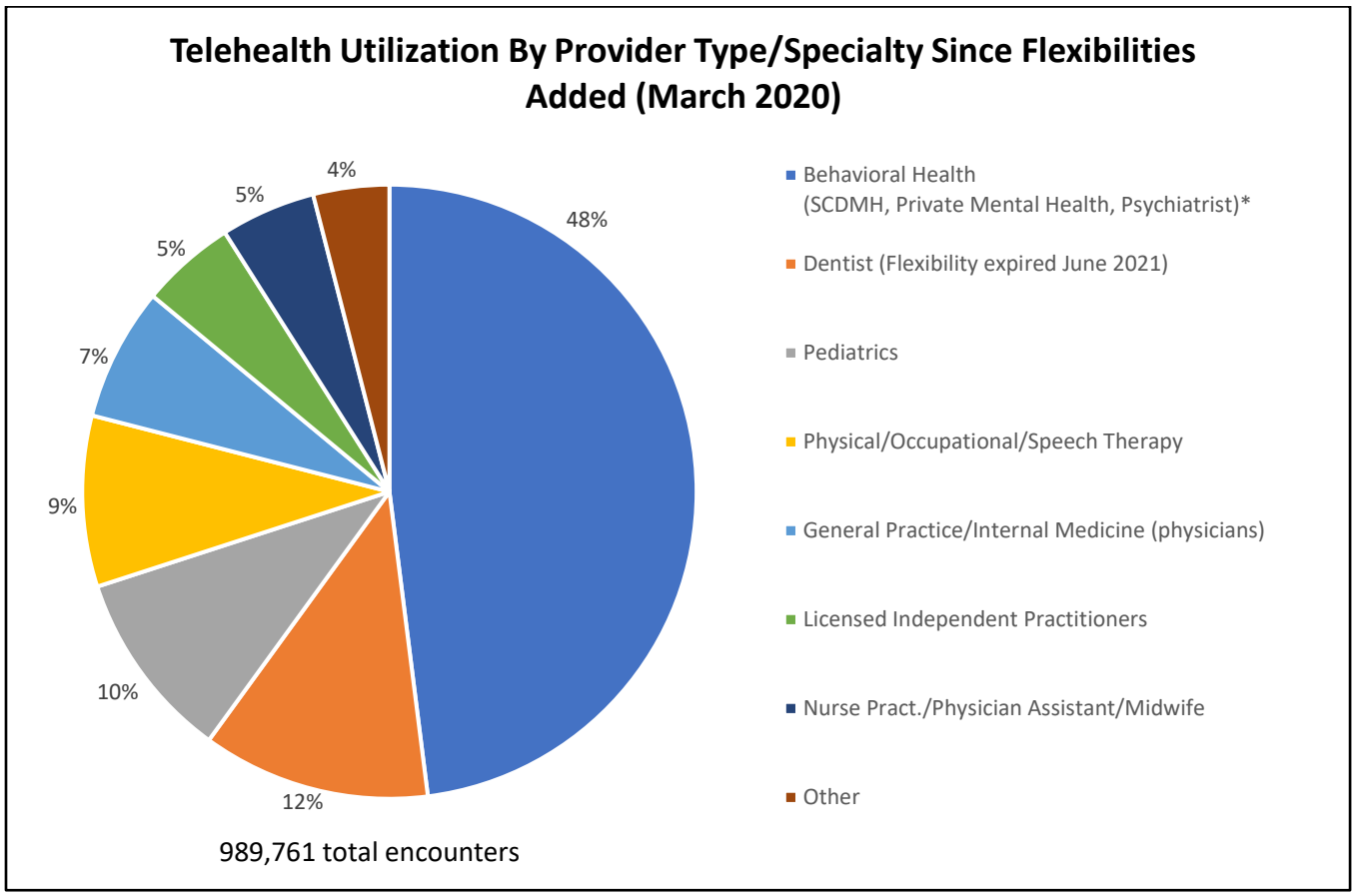

Figure 3 *Telehealth utilization by provider type/provider specialty since the onset of the COVID-19 PHE telehealth flexibilities in March 2020.*
**Top three behavioral health provider types in parentheses*

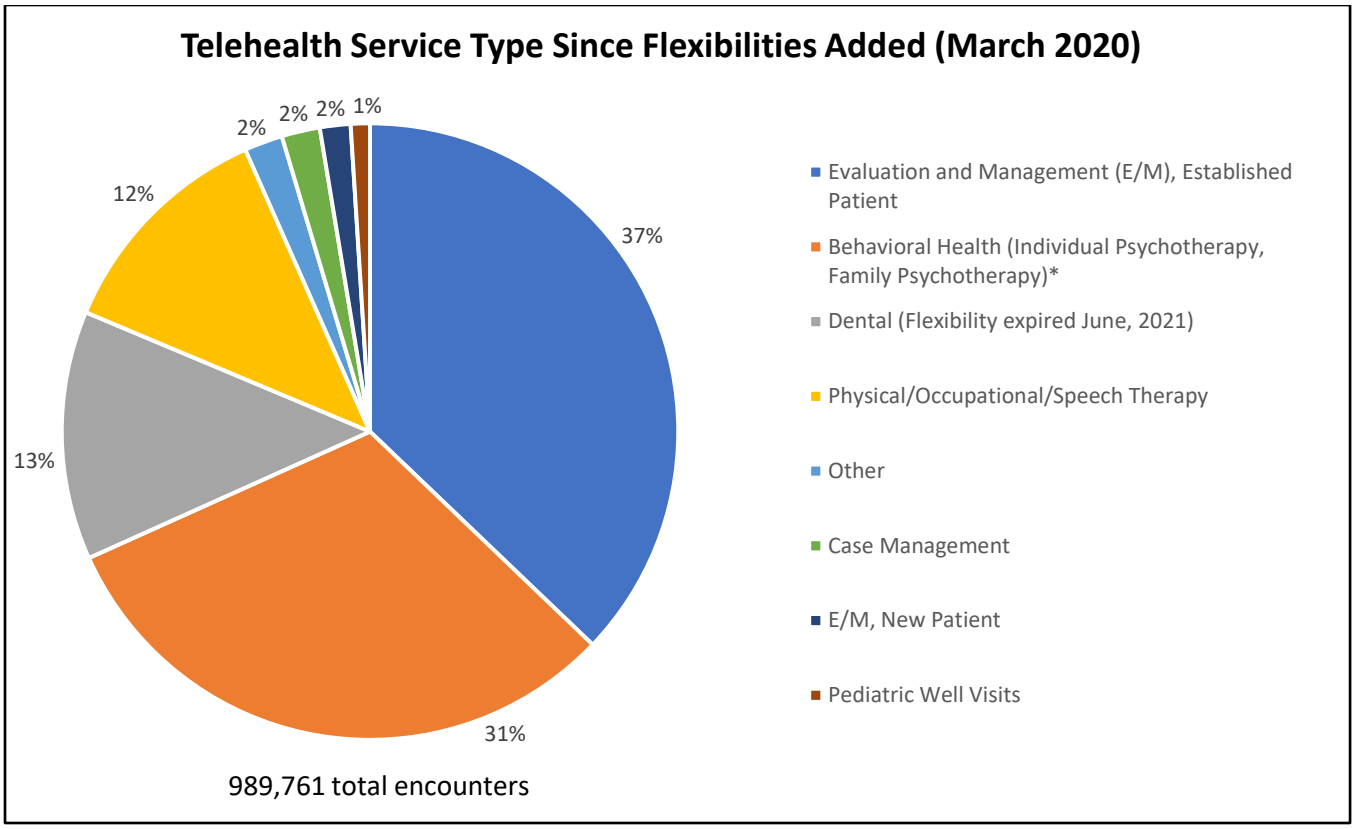

Figure 4 *Telehealth utilization by type of service since the onset of COVID-19 PHE telehealth flexibilities in March 2020*
**Top two behavioral health services in parentheses*

V. Cost Analysis

While the need to act swiftly in response to the COVID-19 PHE allowed for a rapid increase in enabling access to services via telehealth, SCDHHS has not been afforded the opportunity to adequately evaluate the potential fiscal impact and value provided by these services. As such, SCDHHS will perform a detailed cost analysis to better determine the budgetary impact brought on by a long-term increase in the number of services available through telehealth. This analysis will help the department better predict utilization and ensure SCDHHS is able to make data-driven decisions when developing its annual funding request.

Below is a cursory view of telehealth costs per quarter comparing services delivered in person and services delivered via telehealth.

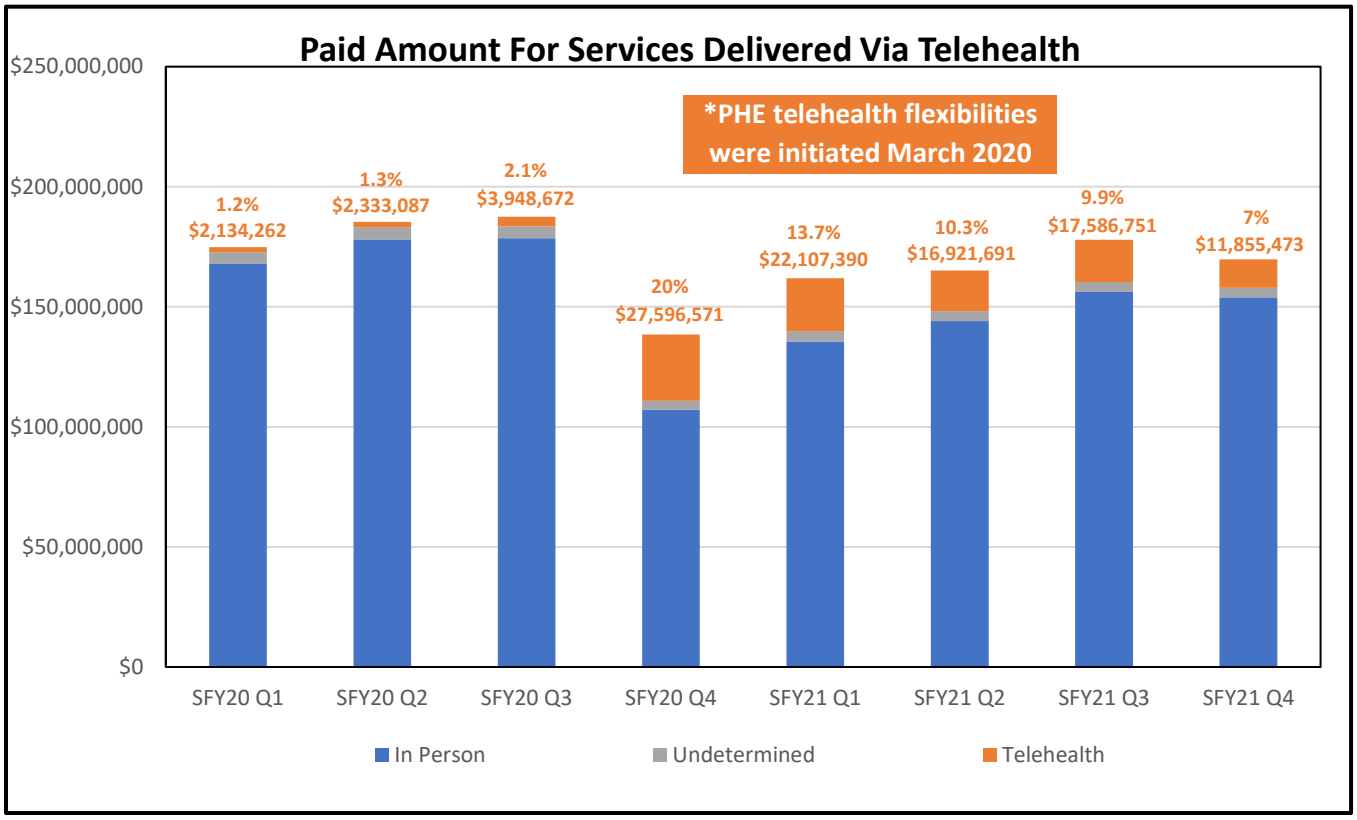

Figure 5 *Comparison of paid amounts by quarter for services rendered in person and via telehealth using telehealth code set in place prior to COVID-19 PHE and codes introduced as PHE flexibilities with the use of a telehealth modifier. Amounts in grey represent services that can be coded with or without the presence of a telehealth modifier, so these services were delivered in person and via telehealth.*

VI. Stakeholder Input

South Carolina Telehealth Alliance Feedback and Recommendations:

The South Carolina Telehealth Alliance (SCTA) is charged with the continued development of a statewide telehealth network[1]. This network is a statewide collaboration of organizations who collectively advocate for telehealth services. The SCTA has provided information and recommendations for SCDHHS to consider in evaluating future coverage policies. Below are the items the SCTA included as key payer priorities in a report it sent to SCDHHS on Sept. 15, 2021. This includes the overarching recommendation to align with CMS covered codes and to extend the temporarily expanded telehealth coverage through 2023 for further study.

SCTA key priorities:

- Permanent removal of originating site restrictions
- Coverage of all CMS-approved mental health and registered dietician provider types as well as rehabilitation therapists
- Permanently allow FQHCs and RHCs to serve as distant sites for telehealth
- Continue coverage of virtual check-ins and audio-only telehealth services
- Cover chronic care remote patient monitoring codes currently covered by CMS
- Cover interprofessional internet consultation (e-Consult) codes covered by CMS
- Cover behavioral health integration codes covered by CMS

To view the full document provided by the SCTA, please see Appendix A of this report.

Managed Care Organizations Feedback and Recommendations:

SCDHHS has received feedback from each of the four South Carolina Medicaid managed care organizations (MCOs) who were active throughout the COVID-19 PHE related to the flexibilities created during the PHE. Survey responses from the MCO plans have been compiled and included below. The below list summarizes the telehealth flexibilities and groups each by MCO preference for consideration in making the flexibility permanent, allowing the flexibility to end, or continued evaluation of the flexibility.

The majority of Medicaid MCO plans are in favor of making the following flexibilities permanent:

- Telephonic care provided by a physician, NP or PA (Bulletin 20-004)
- Telephonic care provided by a LIP (Bulletin 20-004)
- E/M services provided by a physician, NP or PA regardless of patient location (Bulletin 20-005)
- Telehealth services provided through an FQHC or RHC (Bulletin 20-007)
- Telehealth services provided for behavioral health (Bulletin 20-009)
- Extension of telehealth to local authorities consistent with Department of Alcohol and Other Drug Abuse Services (DAODAS guidance) (DAODAS memo)

The majority of Medicaid MCO plans recommend the following flexibilities sunset at the end of the COVID-19 PHE:

- Telephonic care provided by PT, OT, ST (Bulletin 20-008)
- Telephonic parent-directed activities (Bulletin 20-011)
- Allow remote supervision of Registered Behavior Technicians in a face-to-face setting (Bulletin 20-011)
- Telehealth care provided by PT, OT, ST associate-level assistants (Bulletin 20-016)

Medicaid MCO plans did not reach a consensus recommendation on the following flexibilities:

- Telehealth services for well visits/EPSDT (Bulletin 20-015)
- EPSDT telehealth services provided through an FQHC or RHC (Bulletin 20-015)

- Telehealth services for new patients (Bulletin 20-016)

In summary, the table below includes the combined recommendations from South Carolina stakeholders and their preference to add the flexibility as permanent service, allow the flexibility to end with the PHE, or continue to evaluate the flexibility.

South Carolina Stakeholder Recommendations Regarding Current COVID-19 PHE-related Telehealth Flexibilities	Make Flexibility Permanent	Sunset With End of PHE	No Stakeholder Consensus Reached
Waive originating site restrictions (patient home allowed as referring site)	☑		
Continue allowing additional behavioral health services via telehealth for physicians, NPs, PAs and LIP providers	☑		
Permanently allow FQHCs and RHCs to serve as distant sites for telehealth	☑		
Continue coverage of virtual check-ins and audio-only telehealth services	☑		
Extension of telehealth to local authorities consistent with DAODAS guidance	☑		
Cover telephonic services provided by PT, OT, ST		☑	
Telephonic parent-directed activities		☑	
Allow remote supervision of Registered Behavior Technicians in a face-to-face setting		☑	
Telehealth care provided by PT, OT, ST associate-level assistants		☑	
Telehealth services for well visits/EPSDT			☑
Telehealth services for well child/EPSDT visits through an FQHC or RHC			☑

☑ SCTA Recommendation ☑ Medicaid MCO Recommendation ☑ Both

<u>Additional Stakeholder Telehealth Recommendations Not Added During COVID-19 PHE:</u>

- Cover chronic care remote patient monitoring codes currently covered by CMS
- Cover interprofessional internet consultation (e-Consult) codes covered by CMS
- Cover behavioral health integration codes covered by CMS

References:

1. South Carolina 2020-2021 Budget Proviso 117.119

VII. National Overview

Centers for Medicare & Medicaid Services (CMS):

In the 2022 Medicare Physicians Fee Schedule, there are approximately 270 telehealth services, 160 of which were added on a temporary basis during the COVID-19 PHE. CMS is considering permanently keeping the temporary additions to the list of approved telehealth services. These temporary services have been divided into three groups:

1. Codes that will become permanent
2. Codes that will be removed when the PHE expires
3. Codes that will remain on the list through Dec. 31, 2023 for further evaluation ("Category 3" codes)

As CMS continues to evaluate the temporary expansion of telehealth services that were added to the telehealth list during the COVID-19 PHE, CMS is proposing to allow certain services added to the Medicare telehealth list to remain on the list to the end of Dec. 31, 2023, so that there is a glide path to evaluate whether the services should be permanently added to the telehealth list following the COVID-19 PHE.

Additional information related to the CMS Medicare Physician Fee Schedule can be found at www.cms.gov/MedicarePhysicianFeeSched.

Medicare Payment Advisory Commission (MedPAC):

The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency established by the Balanced Budget Act of 1997 to advise the U.S. Congress on issues affecting the Medicare program. In addition to advising the Congress on payments to health plans participating in the Medicare Advantage program and providers in Medicare's traditional fee-for-service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare.

Two reports, issued in March and June each year, are the primary outlets for Commission recommendations. In addition to annual reports and occasional reports on subjects requested by the Congress, MedPAC advises the Congress through other avenues, including comments on reports and proposed regulations issued by the Secretary of the U.S. Department of Health and Human Services, testimony, and briefings for congressional staff.

In the most recent report, MedPAC shares the following recommendations related to telehealth following the COVID-19 PHE:

Policymakers should temporarily continue the following telehealth expansions for a limited duration (e.g., one to two years after the PHE) to gather more evidence about the impact of telehealth on access, quality, and cost, and they should use this evidence to inform any permanent changes.

During this limited period:

- Medicare should temporarily cover certain telehealth services when they are provided through an audio-only interaction if there is potential for clinical benefit.
- Medicare should temporarily pay for specified telehealth services provided to all members regardless of their location.
- Medicare should temporarily cover selected telehealth services in addition to services covered before the PHE if there is potential for clinical benefit.

To view the full MedPAC report, please visit www.MedPAC.gov/March2021report.

VIII. SCDHHS Considerations Moving Forward

Due to the COVID-19 PHE, and the need to implement telehealth changes swiftly, telehealth has become a vital part of delivering care in South Carolina. As the transition out of the current PHE nears, SCDHHS will continue to work with stakeholders, monitor state and national trends, and rely on Medicaid data to develop evidence-based and data-driven coverage policy that will best serve the Medicaid members and taxpayers of South Carolina.

The items below include recommendations that are based on stakeholder feedback, Medicaid data, and national trends regarding telehealth flexibilities. The inclusion of these considerations does not represent a guarantee these services, modalities, provider types, and places of service will become permanent policy additions, but these policy considerations currently appear to increase access, cost efficiency and quality of care.

SCDHHS Telehealth Policy Considerations:

1. Continued evaluation of services that may achieve the department's access, cost and quality goals
   CMS has proposed extending the telehealth services added during the COVID-19 PHE through Dec. 31, 2023. The extension would provide time for CMS to evaluate whether certain telehealth flexibilities should be made permanent. Following the lead of CMS, SCDHHS agrees that it would be prudent to allow additional time for evaluation of the telehealth flexibilities that have been implemented during the PHE.

   As such, in alignment with SCTA, CMS, and MedPAC recommendations, SCDHHS will continue to evaluate services that may potentially benefit South Carolina's Medicaid members. As services, provider types, and program models are identified and validated through collaboration with stakeholders, SCDHHS aims to carefully evaluate any telehealth elements that exhibit potential benefits for inclusion into permanent policy.

2. Add patient home as an approved referring location
   Allowing the patient home as an approved originating site is in alignment with SCTA, Medicaid MCO, and MedPAC recommendations.

   During the PHE, originating site restrictions were temporarily removed. This allowed patients to receive telehealth services in their homes instead of having to travel to a clinic site. Last year in South Carolina, over 1.2 million visits were performed across the state with the vast majority video-based and directly with the patient in their home. Maintaining HIPAA compliance and security of connectivity and patient information will be a key component in the success of permanently removing originating site restrictions to allow the patient home as an approved referring site. Equally important will be the ability of members to access necessary equipment and adequate broadband connectivity for telehealth encounters.

3. Removal of behavioral health provider type restrictions
   In addition to aligning with SCTA and Medicaid MCO recommendations, there is a demonstrated need for increased access to mental health resources in South Carolina. The state ranks 45th in terms of access to mental health services and nearly 1 in 5 adult South Carolinians have a mental health disorder.[1] Moreover, mental health professionals are concentrated in urban areas of the state, making access particularly challenging among rural communities.

4. Add audio-only & brief check-in codes
   The permanent addition of audio-only (telephonic) and brief check-in services post-PHE are in alignment with SCTA, Medicaid MCO, CMS, and MedPAC recommendations.

   Use of audio-only telephonic services are recommended only when interactive video telehealth services are unavailable and when telephonic service is deemed medically appropriate for the underlying covered service. When appropriate, audio-only telehealth has been an important tool to meet the healthcare needs of rural, elderly, and low-income patients during the PHE, many of whom may lack access to the appropriate technology, broadband, or digital literacy needed to utilize video-based services.

In order to ensure the adoption of effective and efficient telehealth services to the Medicaid population, SCDHHS will continue to be engaged in the following:

- Collaboration with stakeholders:
  SCDHHS staff will continue to work with valued stakeholders both in South Carolina and nationally to ensure its post-COVID-19 PHE telehealth policy encompasses the tenets of cost, quality and access. Further discussion will likely be required for many services that have been added as flexibilities and those that have not yet emerged. The development of strong working relationships with telehealth leaders will be key to ensuring the best possible coverage policy for the Medicaid members of South Carolina.

- Identifying those services most valuable to the Medicaid population:
  While the telehealth benefits provided by Medicare serve as a useful benchmark for other payers, the Medicaid population is considerably different. SCDHHS plans to continue evaluating the services provided by other payers through telehealth, and adopt those services that are evidence-based, cost-efficient, and aligned with the needs of the Medicaid population. At present, SCDHHS is also interested in exploring those additional services and providers able to enhance access to in the areas of behavioral health, prenatal care, and services that can benefit the children of South Carolina.

- Provider and member feedback:
  SCDHHS will seek further input on the adoption of telehealth services from the provider community as well as Medicaid members. In order to gain a better understanding of appropriate services, modalities, benefits, and barriers, SCDHHS will conduct provider and member surveys designed to obtain feedback from these critical stakeholders.

References:

1. Mental Health America Inc. Access to Care Ranking 2021. Retrieved from: https://mhanational.org/issues/2021/mental-health-america-access-care-data

SOUTH CAROLINA
Telehealth
ALLIANCE

Information and Recommendations Regarding Sustained State-level Telehealth Reimbursement and Coverage After the Public Health Emergency Declaration

Since March 2020, healthcare organizations of all sizes have relied on telehealth to provide essential healthcare services to their patients during the COVID-19 pandemic, thanks to temporary coverage expansions during the Public Health Emergency (PHE) declaration. While certain flexibilities have been solidified through 2023 at the federal level, many state Medicaid agencies and private payers are currently evaluating future plans for telehealth coverage. Uncertainty around the future of the expanded coverage negatively affects providers and patients, as telehealth has become both an important component of healthcare operations and patients' access to care. In order to truly leverage the benefits of telehealth, healthcare providers must plan staffing and build appropriate infrastructure, which may, in turn, lower the cost of care and expand access to patients. In the following memorandum, The South Carolina Telehealth Alliance (SCTA) has provided information and recommendations as SC payers evaluate their future coverage policies, including the overarching recommendation to align with CMS covered codes. At the very least, we urge SC Medicaid and private payers to extend the temporarily expanded coverage through 2023 for further study and informed future permanent recommendations.

Table of Recommendations

SOUTH CAROLINA
Telehealth
ALLIANCE

Recommendation: Permanently remove originating site restrictions

Description

- During the PHE originating site restrictions were temporarily removed, allowing patients to receive telehealth services in their homes instead of having to travel to a clinic site. Last year in South Carolina, over 1.2 million visits were performed across the state with the vast majority video-based and directly with the patient in their home.[1]
- All outpatient specialties utilized video visits during the pandemic, with the percentage of visits performed virtually following similar trends across the country.
- These trends have continued to stabilize by specialty and are now predictable. Evolving patterns of use by specialty indicate that new patient visits are more often low acuity and are used for both new and established patients, while telehealth is being leveraged more frequently for established visits for more complex patients.[2]

Payer Coverage Considerations

- *Virtual care utilization trends are consistent across specialties*. Physician specialty types have utilized virtual visits in consistent patterns nationally, indicating clinical judgement and appropriateness is consistently applied.[3] While specialty-specific care protocols are anticipated to emerge in the near future, it can be expected that the providers will continue to utilize virtual care at current stable levels, which range across specialties from low single digit percentages to over 40% virtual, and over 70% virtual for some mental health providers.[4]
- *Virtual care can serve as adjunct to in-person care.* Incentivizing use of telehealth as part of the care continuum will encourage the most efficient application of telehealth services to in-person visits. Mechanisms to encourage this include:
    - Allowances for use of virtual care to achieve certain value-based care metrics and pay-per-performance arrangements.
    - It is currently difficult to precisely assess changes in the cost of care delivery using pandemic-related data, as support staffing and infrastructure are dynamic. However, moderate reduction in payment for virtual care may be appropriate, particularly in the setting of value-based contracts and other incentivized care plans.
        - Private Insurers: A 5-10% reduction in payments have been deemed reasonable to continue virtual care at appropriate levels while encouraging in-person care for comprehensive assessments, particularly while the payer and provider have a value-based care arrangement.[5] While limited data exist, this is in line with a similar improvement in no-show rates for the use of virtual care and encourages efforts to adopt efficient models.
        - Medicaid: Medicaid reimbursements trend lower and such payments are essential for many safety net practices, so a period of evaluation of impact on those practices is recommended before implementing a change in fee structure.
        - Facility Fees: Where applicable, facility costs should continue to be reimbursed until the scope of payment adjustments can include the costs of technology and staffing to perform efficient virtual visits.

- *Ongoing Coding and Documentation Education.* As high-quality care delivery includes use of both in-person and virtual care, referral to in-person care from a virtual visit should be expected and easily available. Continued education regarding appropriate documentation and coding when a virtual care modality is determined to be inadequate by the provider will also reinforce the hybrid model of care delivery.
- *Addressing concerns over fraud and overuse*. While there is little compelling evidence that continuing expanded telehealth policies will lead to increased healthcare spending post-pandemic, concerns persist over fraud and overuse. Although telehealth increased exponentially at the onset of the pandemic, rates have tended to settle around 20%, and visit volumes have not exceed pre-pandemic levels.[6] However, as virtual care continues post-pandemic, it is reasonable to have increased coding audits for a period of time. Audits and safeguards could address:
    - Outlier clinicians with irregular telehealth billing patterns, including limited use of in-person care outside what is expected for specialty.[7]
    - Appropriate medical decision management coding for assessment performed.
    - Review of patterns of care with limited in-person care associated with high-cost medical interventions, such as the prescription of durable medical equipment (DME) over a certain dollar amount.[7]

References

1. *2020 Annual Report - SC Telehealth*. South Carolina Telehealth Alliance. (n.d.). Retrieved from: https://sctelehealth.org/-/sm/sctelehealth/f/reports/2020-scta-annual report.ashx.
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Recommendation: Cover all CMS approved mental health and registered dietician provider types as well as rehabilitation therapists

Description

- Clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals are currently CMS-approved distant site practitioners who can furnish and receive Medicare payment for covered telehealth services.
- Allowing these South Carolina-licensed practitioners, as well as licensed professional counselors, to receive payment for their Medicaid services supports the growth of resource-efficient and sustainable business models that use interdisciplinary, collaborative care teams and address statewide health epidemics, such as obesity and opioid use disorder.
- During the COVID-19 public health emergency, rehabilitation therapists were reimbursed for telehealth services provided to patients directly in their homes. Though not currently permitted by CMS, coverage of rehabilitation services via telehealth would enable cost-effective, high-quality care and help reduce geographic disparities in access.

Payer Coverage Considerations

Mental Health Providers

- There is a demonstrated need for increased access to mental health in SC. Among states, SC ranks 45th in terms of mental health care access, yet nearly 1 in 5 adult South Carolinians have a mental health disorder.[1] Moreover, mental health professionals are concentrated in urban areas of SC, making access particularly challenging among rural communities.[2]
- Telehealth has become the predominant modality for mental health provision for many practitioners. At MUSC many mental health clinical areas exceed 70% of visits occurring virtually, accounting for well over 400 clinical encounters daily. In addition to scheduled new and established visits, longstanding telehealth programs in this domain include support of primary care clinics, inpatient consults, emergency room consults, school-based consults, and emergency room diversion initiatives.
- Telemental health can be effectively delivered by practitioners with non-MD backgrounds. Several clinical programs offered across the state routinely use non-MD practitioners to deliver telemental health care, including licensed clinical psychologists, social workers, clinical psychology trainees (e.g., postdoctoral fellows, residents, clinical counseling trainees), and licensed professional counselors working under the supervision of psychologists and psychiatrists.
    - Some examples offered through MUSC since 2015-2016 include:(1) the Telehealth Outreach Program (TOP), which provides mental health services to low-income children and families; (2) Women's Reproductive Behavioral Telehealth program (WRBT), which provides maternal mental health and substance use treatment to pregnant and postpartum women; and (3) Trauma/Telehealth Resilience and Recovery Program (TRRP), which provides multidisciplinary needs-adjusted care to adults and children who develop posttraumatic stress disorder or depression after traumatic injury.
    - Notably, a number of clinical trials have been conducted at MUSC and regionally/nationally that have illustrated high patient satisfaction with telemental health care as well as clinical and functional outcomes that match outcomes for in-person care. All of these trials were conducted

with non-MD practitioners delivering services, consistent with the programs described above. These trials found that:

- Telemental health care increases the reach of evidence-based mental health care without diminishing its effectiveness.[3,4,5,6,7]
- Patient satisfaction with care is equal across telehealth and in-person modalities.[3,7,8]
- Telehealth care yields cost benefits (e.g., lower healthcare utilization costs 1-year post-treatment for depression).[9,10]

  - Consistent with these findings, the MUSC TOP, WRBT, and TRRP programs described above consistently have yielded strong patient satisfaction and clinical and functional outcomes data.[11,12,13]

- Multidisciplinary care is superior care and is facilitated by telehealth-based solutions. The use of telemental health services has not presented any major challenges or barriers to multidisciplinary care and, in fact, has facilitated the capacity to deliver multi-disciplinary services more efficiently. Patients who receive multidisciplinary services in-person typically are required to travel to different hospital settings, often across multiple days, to receive services. Telehealth-based multidisciplinary care is more accessible, more convenient, and yields high patient satisfaction.
- Telemental health providers can adhere to the same policies that apply to in-person care. As our telehealth programs have evolved and become more advanced, SC providers have developed the capacity to complete treatment consent processes seamlessly using established platforms (e.g., doxy.me) that are widely available and integrated into health systems and the electronic medical records, assist patients in resolving technology challenges efficiently, and involve MD providers in care as appropriate. Telemental health services delivered in patients' homes and satellite clinics can adhere to all of the same policies that govern traditional in-person, office-based mental health services.
- Metrics-informed care should be encouraged for in-person and telehealth services. The use of metrics-informed care will allow continuous evaluation as well as quality improvement opportunities to ensure that patient satisfaction is high, quality of care is high, and that clinical and functional patient outcomes are strong and continue to be consistent with in-person care. This should be used both for in-person and telehealth-based services, and will support transparency in ensuring that providers and programs using telemental health services are adhering to, and can provide continued evidence of, standards-based practice.

Registered Dieticians (RDs) or Nutritional Professionals

- Telehealth allows nutrition counseling to be delivered to more patients across the state without requiring patients to travel and outside their medical homes. Nutrition counseling is a key intervention needed to combat South Carolina's diabetes and obesity epidemic; however, there is a lack of qualified registered dietitians to provide their evidence-based services consistently throughout our state.
- Covering telehealth nutrition consultations for Medicaid patients would also help our state achieve the South Carolina Obesity Action Plan goals (H.1.1b and H.2.7b) to increase the number of adult and pediatric patients that receive nutritional counseling services by a dietitian.[14]
- A recent randomized controlled trial evaluated the efficacy of a registered dietician telehealth program to improve the health of diabetic patients and demonstrated significant improvement in the number of clinical measures (e.g. A1c, blood pressure) at follow-up compared to the control group.[15] A systematic

review and metal-analysis of DTC for diabetes management, which includes nutrition education, found that the interventions were effective in improving glycemic control for patients with diabetes, reducing the number of hospitalizations, and had high levels of patient satisfaction.[16]

Rehabilitation Therapists: Physical Therapists (PTs), Speech Therapists (SLPs), and Occupational Therapists (OTs)

- During the pandemic telehealth use among all provider types accelerated, including the use among rehabilitation therapy providers.
- Certain PT, OT, and SLP services can effectively be delivered via telehealth. The literature demonstrates that many therapeutic assessments and treatments delivered via telehealth are valid and reliable[17,18,19] and can be associated with similar outcomes to in-person care.[20,21] Moreover, rehabilitation-related therapies are often most effective when adapted to a patient's life and home environment.
- Rehab clinicians have demonstrated clinical discernment in determining rehab services suitable for telehealth. During the period of authorization and payment to provide virtual services during the pandemic, MUSC's PT, OT, and SLP providers conducted nearly 3000 visits. While this provides important access for specific patients, the overall proportion of care provided virtually is small at 4%. This indicates that these therapy-providing clinicians use prudent clinical judgment when determining which patients would most benefit from telehealth visits.
- As with other telehealth services, provisions can be implemented to help avoid fraud and abuse (e.g., frequency limits, periodic in-person requirements, etc.).

Resources

- MUSC's Telemental Health Programs: Telehealth Outreach Program (TOP), Women's Reproductive Behavioral Telehealth (WRBT), & Trauma Resiliency & Recovery Program (TRRP)
- Telebehavioral Health Center of Excellence (Mid-Atlantic TRC)
- Medicare Telehealth Services and Registered Dietitians (Academy of Nutrition and Dietetics)
- State Occupational and Physical Therapy Telehealth Laws and Regulations: A 50-State Survey (CCHP)

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SOUTH CAROLINA Telehealth ALLIANCE

Recommendation: Permanently allow federally qualified health centers (FQHCs) and rural health centers (RHCs) serve as distant sites for telehealth

Description

- Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are critically important healthcare providers in South Carolina, specifically for SC's rural and underserved communities.
- Before the COVID-19, FQHCs and RHCs were able to be reimbursed by Medicare as originating sites for telehealth, but were not able to serve as distant sites, meaning they could not be reimbursed for providing care via telehealth directly to their patients.
- During the COVID-19 pandemic Public Health Emergency declaration, CMS temporarily allowed RHCs and FQHCs to serve as distant sites for their patients and be reimbursed by Medicare, and SC DHHS followed suit.

Payer Coverage Considerations

- Covering FQHCs and RHCs as distant sites for telehealth improves health equity.
    - Serving special populations: Nationally, health centers care for more than 1 in 5 Medicaid members, and 63% of health center patients are members of racial/ethnic minorities. Additionally, health center patients tend to suffer from chronic conditions at higher rates than the general populations.[1]
    - Decreasing travel burden: Health center patients are by definition a lower income patient population, and in turn are less likely to be able to take time from work for medical appointments, or have access to reliable transportation.
- Coverage of telemedicine services should be looked at through the lens of value.[2]
    - High value telemedicine services include those that are focused not only on the condition treated, but the patient receiving care.[2] Patients for whom telehealth provides increased access rather than additive access, such as those living in rural areas or of lower economic status tend to experience more access barriers. For these patient populations telemedicine services should be considered high-value, as the patients may not receive care any other way.

Resources

- National Association of Community Health Centers (NACHC) Telehealth Website

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SOUTH CAROLINA Telehealth ALLIANCE

Recommendation: Continue coverage of virtual check-ins and audio-only telehealth services

Codes: HCPCS code G2010, HCPCS code G2012, HCPCS code G2252, 99441, 99442, 99443, BH Codes

Code	Description	Provider Time
HCPCS code G2010	Remote evaluation of image/video submitted by established patient	NA
HCPCS code G2012	Brief check-in by MD/qualified health professional (for established patients)	5-10 minutes medical discussion
HCPCS code G2252	Brief check-in by MD/qualified health professional (for established patients) – temporarily allowed, included as permanent in proposed 2022 physician fee schedule	11-20 minutes medical discussion
99441	Telephonic E/M	5-10 minutes medical discussion
99442	Telephonic E/M	11-20 minutes medical discussion
99443	Telephonic E/M	21-30 minutes medical discussion
Behavioral Health Codes (90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90853, 90875)	Various behavioral health services approved by CMS for audio-only during public health emergency and included in proposed 2022 physician fee schedule.	Varies

Description

Virtual Check-Ins (G2010, G2012, G2252)

- Virtual check-in codes allow reimbursement for a provider's engagement with established patients across a number of modalities including phone, secure text messaging, email, or use of patient portal. This engagement can often help the provider and patient determine whether an in-person visit is needed for a particular medical concern.
- To be reimbursed, virtual check-ins may not originate from a related E/M service provided within the previous 7 days nor lead to an E/M service or procedure within the next 24 hours or soonest available appointment.
- Medicare began covering virtual check-ins in 2018, and numerous state Medicaid agencies have followed their lead.
- While use of G2010 can be asynchronous, G2012 and G2252 must involve synchronous audio communication.

Audio-Only Telehealth (99441-99443)

- Audio-only telehealth has been a critical tool to meet the healthcare needs of rural, elderly, and low-income patients during the public health emergency, many of whom may lack access to the appropriate technology, broadband, or digital literacy needed to utilize video-based services.
- Use of audio-only telephonic services are encouraged only when interactive video telehealth services are unavailable and when telephonic service is deemed medically appropriate for the underlying covered service.
- In the CY 2022 Physician Fee Schedule, Medicare has indicated plans to make audio-only telehealth a permanently covered service for the treatment of behavioral health so long as certain provisions are met.

Payer Coverage Considerations

- Coverage of audio-only telehealth supports health equity. Early research on utilization of telehealth during the pandemic has indicated the importance of audio-only telehealth for reaching patients that may face various social determinants of health. Blanket bans on audio-only telehealth exacerbates disparities for patients lacking technology or adequate broadband.
    - Early findings reported by CMS indicated that nearly 1/3 of all telemedicine occurring during the first months of the pandemic were audio-only.[1]
    - Studies suggest the rate of audio-only as compared to video visits to be even higher among patients receiving care at FQHCs,[2] and that FQHCs indicated audio-only care as critical to reaching vulnerable populations.[3] Data shared with the SCTA from partner FQHCs show similarly high-utilization of audio-only services.
    - Other studies point toward reduced likelihood of a full audio-video visit (as compared to audio-only visits) those who are older, Black, and from urban areas.[4]
    - At MUSC, audio-only makes up between 5-10% of telehealth visits across specialties, demonstrating that video is preferred but that audio-only has a significant role in maintaining continuity with patients receiving care from an academic medical center.
- Various provisions can be instituted to prevent fraud and abuse of audio-only visits. As indicated by proposed provisions outlined in the Medicare CY 2022 Proposed Physician Fee schedule, measures can be put in place to avoid misuse of telephonic codes. These include: requiring the person to be at home (to ensure the issue is a matter of connection, not convenience), requiring patients to have established relationships with existing providers, placing limits on number of telephonic visits between in-person visits, etc.
- Virtual check-ins have the potential to prevent unnecessary in-person care and improve patient outcomes.
    - Virtual check-ins have the potential to reduce unnecessary visits to the providers office, presenting cost-saving to both the patient and payer alike.
    - Health systems have begun to innovatively use virtual check-ins to support the care of patients with chronic diseases, in efforts to achieve the quadruple aim of enhancing patient experience, improving population health, reducing costs, and improving clinician experience.[5]
    - MUSC has begun to test the use of virtual check-ins to support care among patients with hypertension, diabetes, and ADHD, but lack of reimbursement limits the ability for these programs to scale.

Resources

- Medicare Telemedicine Health Care Provider Fact Sheet (March 17, 2020) (CMS)
- Early Impact Of CMS Expansion Of Medicare Telehealth During COVID-19 (Health Affairs)
- A virtual visit algorithm: How to differentiate and code telehealth visits, e-visits, and virtual check-ins (American Academy of Family Physicians)

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SOUTH CAROLINA Telehealth ALLIANCE

Recommendation: Cover chronic care remote patient monitoring codes currently covered by CMS

Codes: 99091, 99453, 99454, 99457, 99458

Code	Description
99453	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), plus initial set-up and patient education on use of equipment. (Initial set-up and patient education of monitoring equipment included; do not report 99453 for monitoring of less than 16 days.)
99454	Device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days. (Initial collection, transmission, and report/summary services to the clinician managing the patient.)
99091	Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring), digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified healthcare professional, qualified by education, training, licensure/ regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days.
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified healthcare professional time in a calendar month, requiring interactive communication with the patient/caregiver during the month; first 20 minutes.
99458	Each additional 20 minutes (List separately in addition to code for primary procedure.)

Description

- Remote patient monitoring (RPM) is the collection of a wide range of health data from the point of care, such as vital signs, weight, and blood pressure.
- The data are transmitted to health professionals for monitoring and potential intervention as needed (e.g., medication adjustment, health coaching, triaging to in-person care).
- RPM can support acute and chronic disease management for patients with certain conditions.
- In 2019, Medicare began reimbursing the provision of these services as outlined above, and a little over half of state Medicaid agencies cover RPM to one degree or another.

Payer Coverage Considerations

- RPM has been shown to clinical outcomes by supporting chronic disease management. Research has demonstrated its utility across multiple conditions including diabetes,[1] weight management,[2] cardiovascular disease,[3,4] and COPD.[4]
    - One example of this is MUSC's technology assisted case management program (TACM-2), which focuses on low-income patients with diabetes and hypertension.
        - The program has monitored over 1,500 patients to date, with an average reduction of 1.4% in A1C among enrolled patients.
        - Lack of reimbursement for these services is one of the biggest barriers to growing this program.
- RPM can also be used prevent hospital admissions and readmissions. Research has demonstrated this for various chronic and acute conditions including various cardiac and pulmonary conditions,[5,6] including more recently COVID-19. [7,8,9]
    - During the COVID-19 pandemic, MUSC RPM nurses monitored 1,234 COVID positive patients between March 30 and December 31, 2020, many of whom were older and in underserved populations. The purpose of the program was to provide appropriate triage to patients, keeping at home when possible and referring to PCP/ED in the case of symptom exacerbation.
        - In aggregate, 89% of the 916 patients at moderate or high risk of severe complications were managed solely at home.
        - The program is currently being adapted to the needs of the most recent wave of infections. To free hospital beds, recovering patients will be monitored post-discharge in

order to wean home oxygen with the use of transmitted pulse oximetry, making this a Medicare billable service.

- RPM can be efficient and cost-effective. Numerous studies have demonstrated the cost effectiveness of RPM for chronic conditions like diabetes.[10,11] Moreover, current CMS codes encourage a team-based approach to RPM services, allowing efficient use of nursing and other team members functioning at the highest level of their license, while ensuring physician oversight for the highest quality care.
- Cost containment mechanisms:
    - The provisions of the RPM codes themselves, as designed by CMS, have built-in elements to prevent overuse and abuse (e.g., only allowing one practitioner to bill CPT codes 99453 and 99454 during a 30-day period and only when at least 16 days of data have been collected on at least one medical device).
    - Moreover, current programs in SC have demonstrated that clinicians are skilled in reserving RPM resources for patients who are most in need and meet certain program criteria (e.g., A1C of at least 8% or higher for diabetes RPM).

Resources

- 2021 Medicare Remote Patient Monitoring FAQs: CMS Issues Final Rule (Foley)
- CMS Revises 2021 Remote Patient Monitoring Rules, Issues Correction (Foley)
- Remote Patient Monitoring in the Safety Net: What Payers and Providers Need to Know (CHCF)

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SOUTH CAROLINA Telehealth ALLIANCE

Recommendation: Cover interprofessional internet consultation (e-Consult) codes covered by CMS

Codes: 99446, 99447, 99448, 99449, 99451, 99452

Code	Description	Provider Time
99446	Interprofessional telephone/Internet/electronic health assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review	5-10 minutes medical consultative discussion and review
99447	11-20 minutes of medical consultative discussion and review	11-20 minutes medical consultative discussion and review
99448	21-30 minutes or more of medical consultative discussion and review	21-30 minutes or more of medical consultative discussion and review
99449	31 minutes or more of medical consultative discussion and review	31 minutes or more of medical consultative discussion and review
99451	Interprofessional telephone/Internet/electronic health assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes of medical consultative discussion and review	5 minutes of medical consultative discussion and review
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/ requesting physician or other qualified health care professional, 30 minutes	30 minutes

Description of Services:

- Interprofessional Internet Consultation (eConsult) codes provide reimbursement of provider-to-provider interactions regarding a patient's care. Using these codes, a patient's treating physician or other qualified healthcare professional requests the opinion and/or treatment advice of a consulting physician with specific specialty expertise.
- The consulting provider is able to assist the treating provider with diagnosis and/or management of the patient's problem, decreasing the need for an in-person referral.
- Code detail:[1]
    - 99446-99449 include both real-time discussion and a written report between the two providers *(more than 50% of time must be medical consultative verbal or internet discussion)*
    - 99451 is used for asynchronous consultation including a written report
    - 99452 is used by the requesting/treating provider or other qualified healthcare provider to gather the information needed to request the consult
- Medicare adopted and began reimbursing for these codes in 2018.

Payer Coverage Considerations

- eConsults are cost effective. eConsults are associated with cost savings to payers, as concluded from a randomized study of eConsults versus face-to-face consultations in a statewide federally qualified health center.[2]
- Reduced unnecessary in-person referrals. Primary care providers ask targeted clinical questions and are empowered to treat and manage low-acuity issues.

- Improved communication and coordination increases efficiency. Improved PCP/specialist coordination through eConsults frees up specialist time to focus on more high acuity and complex cases.[3]
- Increases timely access to care. eConsults increase access to specialty care through improved timeliness and decreased appointment wait times.[4] This is especially beneficial in rural and underserved communities which disproportionately experience travel and resource burdens.
- Increased quality and improved health outcomes. With increased access to specialists through eConsults, patients receive quality care in a timely manner, and are less likely to experience negative health outcomes associated with care delays.
- Built-in provisions to prevent fraud and abuse.
    - The patient must consent and agree to cost-sharing.
    - Certain time constraints exist around in-person visits and billing frequency.

Resources

- AAMC Project Core information
- Cost Effectiveness Analysis of Cardiology eConsults for Medicaid Patients
- Center for Connected Health Policy Issue in Focus: New eConsult RCT Shows Significant Savings for Medicaid (paper linked above)
- eConsult Workgroup Resources
- Center for Connected Health Policy Issue Brief: eConsult – A Valuable Telehealth Tool for Increasing Access to Specialty Care
- eConsult Infographic
- North Carolina Medicaid coverage of Provider-to-Provider Store and Forward Telehealth (Virtual Communications)

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Recommendation: Cover behavioral health integration codes (including CoCM) covered by CMS

Codes: 99494, 99492, 99493, 99484, HCPCS code G2214

BHI Codes	Behavioral Health Care Manager or Clinical Staff Threshold Time	Assumed Billing Practitioner Time
Add-On CoCM (Any month) (CPT code 99494)	Each additional 30 minutes per calendar month	13 minutes
BHI Initiating Visit (AWV, IPPE, TCM or other qualifying E/M)†	N/A	Usual work for the visit code
CoCM First Month (CPT code 99492)	70 minutes per calendar month	30 minutes
CoCM Subsequent Months (CPT code 99493)**	60 minutes per calendar month	26 minutes
General BHI (CPT code 99484)	At least 20 minutes per calendar month	15 minutes
Initial or subsequent psychiatric collaborative care management (HCPCS code G2214)	30 minutes of behavioral health care manager time per calendar month	Usual work for the visit code

**CoCM is delivered monthly for an episode of care that ends when targeted treatment goals are met or there is failure to attain targeted treatment goals culminating in referral for direct psychiatric care, or there is a break in episode (no CoCM for 6 consecutive months).
†Annual Wellness Visit (AWV), Initial Preventive Physical Examination (IPPE), Transitional Care Management services (TCM).

The Behavioral Health Integrated Care Model

- Integrating behavioral health into primary care has been widely accepted as an effective strategy for addressing the growing behavioral and mental health care needs of patients, leading to new behavioral health integration (BHI) payment models.
- BHI models leverage trained behavioral health care managers to provide care management services to a panel of patients under the supervision of the treating medical provider.
- Psychiatric Collaborative Care Services (CoCM), is a specific BHI model involving a psychiatrist that provides consultative support to the behavioral healthcare manager.
- Strategic use of integrated behavioral health can improve health and patient experience, while reducing unnecessary costs in time, money, and delays in care.
- Medicare began covering BHI services in 2017, with an increasing number of private payers and 19 state Medicaid agencies now covering as well.
- Telehealth can be used to deliver care management services and/or to provide the psychiatric consultative support to behavioral healthcare manager, adding efficiency to this already effective care model.

Description of Use

- The treating (billing) provider directs behavioral healthcare manager or clinical staff in delivery of BHI services to a panel of patients being treated by that provider for any mental, behavioral health, or psychiatric conditions that would benefit from BHI.
- Clinical staff or the behavioral health manager documents time spent delivering BHI services, and codes are billed (incident to the billing provider) on a monthly basis for these services rendered.
- For CoCM, a psychiatric consultant participates in regular review of patients receiving BHI services to advise on diagnosis, medication management, treatment progression, etc.
- CoCM requires additional documentation in a patient registry to support and document review and guidance provided by psychiatric consultant.

Payer Coverage Considerations

- The benefits of BHI Models are well-documented. The effectiveness and value of integration of behavioral healthcare into primary care is well-documented across the literature.
    - Collaborative care improves mental health outcomes.[1, 2, 3]
    - Enhances patient experience.[4]
    - Reduces costs.[3,5]
- Telehealth BHI models significantly improve patient's mental health and use substantially less time, compared to referral-based telepsychiatry.[6]
- Provisions to prevent fraud and abuse are built in. Documentation/registry requirements for BHI and CoCM help avoid potential for fraud and abuse of BHI/CoCM billing. Some state Medicaid agencies—including New York and California—have required an additional step of attestation on behalf of the billing BHI provider to ensure all components of the CoCM model are being met.[7]

Resources

- CMS Medicare Learning Network – Behavioral Health Integration Resource
- Current state Medicaids and private payers covering BHI / CoCM Codes
- American Hospital Association Value Initiative Brief: Integrated Behavioral Health is High-value Care
- Cracking the Codes: State Medicaid Approaches to Reimbursing Psychiatric Collaborative Care
- Advancing Integrated Mental Health Solutions (AIMS) Center: Collaborative Care (University of Washington)

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